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ABSTRACT

This report provides a summary of the Public Health Service Act Infant Mortality Amendments of 1987 (S. 1441), background information and rationale for the legislation, the text of the bill as reported, views of the Senate Committee on Labor and Human Resources, a statement of approval by the Committee, the Congressional Budget Office cost estimate, a regulatory impact statement, a section-by-section analysis, and specifications of changes the proposed legislation will effect in existing legislation. S. 1441 expands the fiscal year 1988 authorization for Migrant Health Centers by $3 million, the Community Health Centers program by $35 million, the Area Health Education Centers program by $3 million, and establishes a new program to provide grants to public and private nonprofit schools of nursing to operate fellowship programs for the training of nurse midwives and pediatric, family, obstetric, and gynecologic nurse practitioners. The bill requires that priority be given to programs which will train personnel for areas along the U.S.-Mexico border, frontier areas, the Pacific Basin region, and for areas with disproportionately high infant mortality and low birthweight infant rates. (RH)

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PUBLIC HEALTH SERVICE ACT INFANT MORTALITY AMENDMENTS OF 1987

AUGUST 3 (legislative day, JUNE 23), 1987.—Ordered to be printed

Mr. KENNEDY, from the Committee on Labor and Human Resources, submitted the following

REPORT

[To accompany S. 1441]

The Committee on Labor and Human Resources, to which was referred the bill (S. 1441) to reduce the incidence of infant mortality, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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I. SUMMARY OF THE BILL

MIGRANT HEALTH CENTERS

The bill expands the fiscal year 1988 authorization for Migrant Health Centers by $3 million. This additional authorization is intended to increase the resources under this program to enable it to combat high rates of infant mortality through expanded and enriched maternal health and child health services.

COMMUNITY HEALTH CENTERS

S. 1441 expands the fiscal year 1988 authorizations for the Community Health Centers program by $35 million. This additional authorization is intended to increase the resources under this program to enable it to combat high rates of infant mortality through expanded and enriched maternal health and child health services. The bill also requires the Secretary to give consideration to the needs of rural areas designated as frontier areas. The bill requires that fiscal year 1988 appropriations which exceed $418 million for the Community Health Centers program shall be utilized for grants to support special prenatal services and special perinatal coordinated projects.

AREA HEALTH EDUCATION CENTERS

The bill increases the fiscal year 1988 authorization for the Area Health Education Centers program by $3 million and requires that, of fiscal year 1988 appropriations, $3 million shall be utilized for contracts to support programs that will train personnel to offer maternal and child health services in underserved areas. The bill requires the Secretary to give priority to programs which will train personnel for areas along the U.S.-Mexico border, frontier areas, the Pacific Basin region, and for areas with disproportionately high infant mortality and low birthweight infant rates.

NURSE PRACTITIONERS AND NURSE MIDWIVES

The bill establishes a new program, authorized at $4 million for fiscal year 1988, to provide grants to public and private nonprofit schools of nursing to operate fellowship programs for the training of nurse midwives and pediatric, family, obstetric and gynecologic nurse practitioners. Such programs must give priority to applicants who are employed by Community or Migrant Health Centers, or by Indian Health Service Facilities or Native Hawaiian health centers.

II. Background and Need for Legislation

The United States ranks 17th in the world in infant mortality rate, behind Singapore and Hong Kong. Nearly 40,000 of the 3.7 million children who were born in th United States in 1984 died before their first birthday, a rate of 10.8 infant deaths per 1,000 live births. The disparity between black and white infant mortality is particularly alarming; black infants are nearly twice as likely as white infants to die in the first year of life. At our current rate of progress, the United States has little chance of meeting the Surgeon General's goal of reducing the infant mortality rate to 9 per 1,000 live births by 1990.

Two-thirds of all infant mortality can be attributed to those infants born at low birthweight. In 1987, a quarter of a million low birthweight babies will be born. These infants are 40 times more likely than normal birthweight babies to die in the first month of life, and 20 times more likely in the first year. They are also far more likely to have birth defects and mental and physical handi-

caps, which often mean lifelong challenges, hardships, and expenses for themselves, their families and society.

Low birthweight is largely preventable—and at relatively low cost. Early prenatal care can reduce the number of infants born at low birthweight by two-thirds. The Institute of Medicine has estimated that for every dollar spent for prenatal care, $3.38 would be saved in the total cost of caring for low birthweight infants.

Although lowering risk factors through access to prenatal care is the most effective way to prevent low birthweight, millions of women receive little or no prenatal care. National health statistics compiled by the federal government indicate that, in 1983, nearly one quarter of all pregnant women in the United States did not begin prenatal care in the first trimester of pregnancy. Among teenagers and black women, nearly one-half do not receive prenatal care in the first trimester and poor women were twice as likely to receive no or late prenatal care.

The report of the Institute of Medicine (IOM), Preventing Low Birthweight, provides guidelines for the type of medical and health services which could improve the quality of prenatal care. The IOM recommends that several specific components of prenatal care be offered to all women. Among these are: (1) patient counseling on potential problems and interventions; (2) formal risk assessment, including psycho-social and medical assessments; (3) ultrasound imaging for diagnostic purposes; (4) management of behavioral risks such as nutrition counseling and therapy, smoking cessation and substance abuse treatments; (5) prenatal and parenting education; and (6) special medical and health services to deal with specific risks, conditions and problems. For infants, based on the American Academy of Pediatrics' guidelines, routine care consists of a minimum of six visits in the first year of life. These visits should include a physician examination, measurement, developmental testing, and immunizations. There will also be a need for care for common illnesses during this time of life. In addition, high risk infants may need more frequent examinations, home visits, vitamin supplementation, prescription drugs, specialized medical or developmental testing, or rehabilitative services. Parents may also require intensive parenting education.

Significant contributions have been made to increase the access to quality health care for low-income and uninsured families by Community and Migrant Health Centers. Begun in 1965 as eight research and demonstration projects, the program has expanded over the past twenty years into 800 primary health care centers providing comprehensive primary care to nearly six million poor and underserved Americans in 50 states, Puerto Rico, and the District of Columbia.

Of those served by Community and Migrant Health Centers, it is estimated that 60 percent are poor, 48 percent lack any form of health insurance, over one-third are children under the age of 14, and over one-third are women of child bearing age.

However, it has been estimated by the Health Resources and Services Administration that the Community and Migrant Health Centers reach less than one fourth of America's 25 million medically underserved residents.

The Community Health Centers (CHC) and Migrant Health (MH) programs were reauthorized in 1986 for fiscal years 1987 and 1988. However, at that time the authorization levels were "frozen" for fiscal years 1987 and 1988 at the same levels as the fiscal year 1986 Congressional appropriations for these programs—that is, at $400.0 million annually for the CHC program and $45.4 million for the MH program.

Section 5, relating to Area Health Education Centers (AHEC), is aimed at improving maternal and child health care in areas particularly hard-hit by maternal and child health problems. This section addresses the tremendous shortage of health care personnel in the area along the U.S.-Mexican border, and the problems of delivery of health care in sparsely populated, rural or "frontier" areas. AHEC programs will be expanded, targeting resources to these especially needy areas in addition to areas with disproportionately high infant mortality rates. The services actually rendered by the AHECs will serve to fill existing gaps in the delivery of maternal and child health care. More lasting benefits will derive by health care professionals who receive training at AHEC sites, and who remain in these needy areas to practice.

III. Text of the Bill as Reported

A BILL To reduce the incidence of infant mortality.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Public Health Service Act Infant Mortality Amendments of 1987".

FINDINGS

Sec. 2. The Congress finds that—

(1) the United States has made far less progress than other industrialized nations in reducing the infant mortality rate;

(2) the Surgeon General in 1980 established the 1990 Health Objectives for the Nation concerning the provision of prenatal care early in pregnancy and for reducing the incidence of low birthweight babies and infant mortality;

(3) the incidence of low birthweight, which is one leading cause of infant mortality and handicapping conditions (such as retardation, cerebral palsy, epilepsy, and autism) has been reduced only marginally;

(4) insufficient progress has been made in the reduction of the overall infant mortality rate;

(5) despite a declining infant mortality rate, black infants remain twice as likely as white infants to die in the first year of life;

(6) it now appears that the Nation will fail to meet the objectives of the Surgeon General described in paragraph (2);

(7) it is well established that appropriate and timely prenatal care and primary care for infants can reduce infant mortality and improve infant health and are essential if the Nation is to meet objectives of the Surgeon General described in paragraph (2);

(8) it is well established that inadequate prenatal care and infant mortality and disability are highest for those individuals who are poor and are without health insurance;

(9) recent statistics indicate that 1 out of every 3 poor children and 1 out of every 3 women of child bearing age does not have health insurance;

(10) community and migrant health centers were established to provide primary health care to poor individuals and individuals without health insurance;

(11) of the individuals served by such centers, 60 percent are poor, 48 percent lack any form of health insurance, over one-third are children under the age of 14, and over one-fourth are women of child bearing age; and

(12) the services of community and migrant health centers should be expanded to provide increased prenatal care and infant care, including an expansion of the number of health professionals providing such services.

MIGRANT HEALTH CENTERS

SEC. 3. Section 329(h)(1) of the Public Health Service Act is amended by striking out "$45,400,000" the second place it appears and inserting in lieu thereof "$48,400,000".

COMMUNITY HEALTH CENTERS

SEC. 4. (a) Section 330(g)(1) of the Public Health Service Act is amended by striking out "$400,000,000" the second place it appears and inserting in lieu thereof "$435,000,000".

(b) Section 330(c) of such Act is amended by adding at the end thereof the following new paragraph:

"(4) In making grants under this subsection and subsection (d), the Secretary shall give special consideration to the unique needs of frontier areas.".

(c) Section 330(g) *of such Act* is amended by adding at the end thereof the following new paragraph:

"(4) In any case in which the amounts appropriated under paragraph (1) for fiscal year 1988 exceed $418,000,000, the total amount of any such excess shall be available for grants under subsections (c) and (d) to community health centers to support special prenatal services to decrease infant mortality and special perinatal coordination projects to develop and coordinate referral arrangements between community health centers and other agencies, institutions, and organizations that are crucial to the successful management of pregnant women and infants. In making grants from amounts available under the preceding sentence, the Secretary shall give priority to community health centers in areas in which there is a high incidence of infant mortality or in which there is an increased incidence of infant mortality.".

AREA HEALTH EDUCATION CENTERS

SEC. 5. (a) Section 781(a)(1) of the Public Health Service Act is amended—

(1) by inserting "(A)" before "The"; and

(2) by adding at the end thereof the following new subparagraph:

"(B) Under subparagraph (A), the Secretary shall enter into contracts to establish and support area health education center programs which include training of personnel to offer maternal health services and child health services in underserved areas. In entering into contracts under the preceding sentence, the Secretary shall give priority to programs which will train personnel to provide such services in areas along the border between the United States and Mexico, in frontier areas, and in areas in which the rate of infant mortality and low birthweight are disproportionately higher than such rates for the State in which such an area is located.".

(b) Section 781(c)(1) of such Act is amended by inserting before the semicolon a comma and "except that a program described in subsection (a)(1)(B) shall only be required to provide for the active participation in such program of individuals who are associated with the administration of the school and each of the departments (or specialties if the school has no departments) of pediatrics, obstetrics and gynecology, and family medicine".

(c) Section 781(c)(2) of such Act is amended by inserting "except in the case of a program described in subsection (a)(1)(B)," before "provide".

(d) Section 781(d)(2)(C) of such Act is amended—

(1) by inserting "(i) except as provided in clause (ii)," before "provide";

(2) by inserting "or" after the semicolon; and

(3) by adding at the end thereof the following new clause:

"(ii) in the case of a program described in subsection (a)(1)(B), provide for or conduct a medical residency program in obstetrics and gynecology in which no fewer than six individuals are enrolled in first year positions in such program;".

(e) Section 781(d)(2)(F) of such Act is amended by striking out "and nurse practitioners" and inserting in lieu thereof ", nurse practitioners, and nurse midwives".

(f) Section 781(g) of such Act is amended—

(1) by striking out "$18,000,000" the last place it appears and inserting in lieu thereof "$21,000,000"; and

(2) by adding at the end thereof the following new sentence: "Of the amounts appropriated under this subsection for fiscal year 1988, $3,000,000 shall be available for contracts under subsection (a)(1)(B).".

FELLOWSHIPS FOR NURSE PRACTITIONERS AND NURSE MIDWIVES

SEC. 6. Part A of title VIII of the Public Health Service Act is amended by adding at the end thereof the following new section:

"FELLOWSHIPS FOR NURSE PRACTITIONERS AND NURSE MIDWIVES

"SEC. 823. (a) The Secretary shall make grants to public or nonprofit private schools of nursing for the establishment and operation of fellowship programs for the education of nurse midwives and pediatric, family, obstetric, and gynecologic nurse practitioners. Such programs shall meet the guidelines prescribed by the Secretary under subsection (b).

"(b) After consultation with appropriate educational organizations and professional nursing and medical organizations, the Secretary shall prescribe guidelines for fellowship programs for the education of nurse midwives and pediatric, family, obstetric, and gynecologic nurse practitioners. Such guidelines shall, as a minimum, require that such a program—

"(1) extend for at least one academic year; and

"(2) consist of—

"(A) supervised clinical practice; and

"(B) at least four months (in the aggregate) of classroom instruction,

directed at preparing nurses to deliver pediatric, family, obstetrical, and gynecological services, particularly prenatal care and other services designed to reduce infant mortality.

"(c) A fellowship funded under this section shall include, for each year for which the fellowship is awarded, 100 percent of the costs of tuition, books, fees, reasonable living expenses (including stipends), reasonable moving expenses, and necessary transportation.

"(d)(1) In order to receive a fellowship funded under this section, an individual must be a registered nurse.

"(2) In awarding fellowships funded under this section, a school of nursing shall give priority to any applicant who—

"(A) is employed by a facility providing health services to medically underserved populations, such as a community health center, a migrant health center, a facility operated by the Indian Health Service, or a Native Hawaiian health center; and

"(B) has been recommended for the fellowship by the facility described in subparagraph (A).

"(e) No grant may be made for the establishment and operation of a fellowship program under this section unless this application for the grant contains assurances satisfactory to the Secretary that the program meets or will meet the guidelines which are in effect under subsection (b).

"(f) For grants under this section, there are authorized to be appropriated $4,000,000 for fiscal year 1988.".

IV. Committee Views

The Committee recognizes that it is well established that approrpiate and timely prenatal care and primary care for infants can reduce infant mortality and improve the health of infants. The Committee is concerned about the continued high incidence of infant mortality in our country and is committed to aggressive actions to meet the Surgeon General's 1990 objectives in the area of material and child health. Most notably, those objectives relating to prenatal care improvements, reductions in low birthrate, overall mortality reduction for minorities and postneonatal mortality reductions are of great concern. The Committee recognizes that action is necessary to reduce the thousands of unnecessary low birthweight births and hundreds of preventable infant deaths.

Community and Migrant Health Centers were established to provide primary health care in medically underserved areas and among low-income and minority populations, many of whom have

no health insurance. These centers represent ideal locations for targeting efforts to improve access to prenatal and infant health services for poor and uninsured women and infants.

The purpose of this legislation is to directly contribute to the reduction of perinatal mortality/morbidity rates, improve pregnancy outcomes and enable underserved areas to reach the Surgeon General's 1990 infant health goals by:

Improving pregnant women's and children's access to needed health services;

Enhancing the ability of C/MHCs to provide comprehensive perinatal ambulatory care services;

Enriching the services of C/MHCs through addition of staff for outreach, health care, nutrition education, etc.

Better coordination of services between C/MHC and other local public and private providers of medical, health and health-related services;

Increasing the number of Nurse Practitioners and Certified Nurse Midwives at C/MHCs and underserved areas and at Indian Health Service and Native Hawaiian Center sites; and

Expanding educational programs for medical and health personnel in order to improve their ability to deliver maternal health and child health services.

A. COMMUNITY AND MIGRANT HEALTH CENTERS

The Committee intends that all funds appropriated under this authorization shall be used for efforts which, directly or indirectly, will contribute to reduce maternal, infant and child mortality and morbidity.

1. Grants To Develop New Centers, Expand Existing Sites, and Enhance the Provision of Primary and Supplemental Services

Under the provisions of the bill, the first $18 million in appropriations for CHCs that exceed $400 million, and the appropriations for Migrant Health that exceed $45.4 million, should be for general expansion of the programs through a combination of:

Development of new service delivery systems in identified communities where no C/MHC services now exist;

Expansion of service delivery capacity in existing C/MHCs, to provide delivery of services through expanded or additional sites in identified communities where current services are insufficient to meet needs;

Enhancement of current primary and supplemental services at existing C/MHCs to improve quality and scope of care provided to pregnant women and children; or

Better coordination with other statewide services in order to enhance perinatal delivery systems.

The Committee believes that using these funds to establish new centers or expand existing centers (through the addition of new service sites or new personnel, or both) will improve the availability of comprehensive, high quality maternal and infant care. In many high risk areas of the country, pregnant women are unable to find accessible and affordable prenatal care. Following birth, basic care for an infant's health needs may be even more difficult

to locate. The Committee has special concern about areas of the country and States where infant mortality remains unusually high and there are no community services available. Southern States, border States along the U.S.-Mexican border, and frontier areas are identified by the Committee as areas meriting special attention for establishment of new facilities to improve access to care.

These funds should also be made available to meet the costs of hiring additional medical, nursing, ancillary service, or case management personnel, or the costs associated with deploying staff at additional service sites, in order to better serve high risk pregnant women, infants, and children.

While the bill requires that priority for grants supported with certain funds (those amounts appropriated for CHCs in excess of $418 million) must be given to areas with high or increasing incidence of infant mortality, it is also the Committee's intent that development of new service delivery sites, whether through new starts (new grantees) or expansions (existing grantees) should be limited to identified areas which are medically underserved areas and have a high or increasing rate of maternal, infant, or child health mortality or morbidity, including low birthweight, whether for the general population or for population subgroups (racial or ethnic minorities, those with below-poverty incomes, or the like).

For purposes of this act, a high incidence of infant mortality is considered to be a rate which is greater than the infant mortality rates for the Nation, either as a whole or by race. In 1984, these rates were 10.8 infant deaths per 1,000 live births for all races, 9.4 per 1,000 for whites, and 18.4 per 1,000 for blacks. The Secretary, in making grants to projects serving other populations, such as Native Americans or Hispanics, should apply appropriate mortality rates as developed by the National Center for Health Statistics for infants from each special racial and ethnic minority. The Secretary should also give special consideration to areas in which the neonatal (birth to 28 days) or postneonatal (29 days to one year) infant mortality rates are higher than average, even though the overall infant mortality rate may be at or below the national average and to areas with high concentrations of minority populations other than blacks. The Secretary should also give special consideration to areas which may be below overall the national average, but which have seen a dramatic increase in the incidence of infant mortality in recent periods.

Some communities may have a high concentration of Hispanic, Native American, Alaskan Native or Asian mothers and infants who may have increased health risks demonstrated through specialized studies. In these cases, the Secretary should consider racially and culturally appropriate statistics and special studies in prioritizing grant allocations. The Secretary is also directed to compare infant mortality rates presented in any grant proposal to appropriate racial and ethnic group rates.

While the Committee expects these new funds to assist high risk pregnant women, infants, and children, the Committee does not intend exclusive services must be provided to these populations by new programs established through this funding. The Committee agrees that through general enrollment, new C/MHC sites will be

providing care to a significant number of pregnant women and children.

Further, it is the Committee's intent that the Secretary make grants designed to enhance the scope and depth of primary and supplemental services offered by centers pursuant to Sections 329 and 330 of the Act. This is especially important in the case of high risk pregnant women and infants because the development of new technology and risk assessment techniques has dramatically outstripped centers' service capacity and grant levels. The Committee also intends that centers have the latitude to use these enhancement funds toward meeting their maternity and infant patients' hospitalization needs when, in the opinion of the centers, hospitalization is essential to patient management and other resources are unavailable.

2. Grants To Provide Outreach and Patient Management and Assistance Services and To Engage in Perinatal Coordination

The Committee supports outreach, and patient management and assistance services in a broad effort to reduce infant mortality. Enhanced medical care through new sites and additional personnel are fundamental to reduce infant mortality. In the case of low-income and racially, geographically, ethnically, and culturally isolated families, moreover, it involves aggressive efforts to coordinate a smoothly functioning perinatal and infant care system in which the range of agencies, institutions and providers serving the population can work smoothly together with common goals.

Therefore, the Committee intends that amounts appropriated over $418 million be used to fund outreach and patient management services as well as special perinatal/infant coordination projects between health centers and other agencies, institutions, and organizations that are crucial to successful management of pregnant women and infants.

The Committee intends that funds in excess of $418 million be used for outreach, patient management services and care. These services are defined as activities designed to get women and children into care as early as possible, keep them in care, and make the care system responsive to their needs. Specific services (many of which are already recognized as primary and supplemental services) include:

Casefinding, including the use of lay and professional outreach workers;

Translation assistance as well as other activities that reduce barriers to care such as transportation and child care;

Patient and provider education regarding what medical and health services, assistance and resources are available in a community and how to gain access to them;

Parenting and perinatal patient education classes; and

Coordination of services with other perinatal care providers.

The Committee recognizes that these services can best be provided through employment of additional staff, especially lay outreach workers, and through the development of a "team approach", involving such outreach workers and the centers' clinical staff. It is the provision of these types of services which has made the C'MCH

programs unique and particularly successful in effectively caring for high risk, medical underserved populations.

In addition, the Committee supports funding of up to $3 million of the additional funds for centers to improve the quality and responsiveness of regionalized perinatal care services for their patients. Centers might accomplish these objectives through a variety of activities. These might include: developing or upgrading transportation systems which would be suitable for high risk mothers and infants; training staff to provide better risk assessment, more appropriate referral, or better follow-up care; developing improved communication systems between centers and more specialized medical centers; providing prenatal outreach to better ensure timely entry into appropriate care; and developing a system for accelerated eligibility into public programs such as the Supplemental Food Program for Women, Infants and Children (WIC), Medicaid, and other indigent health care financing programs. These grants would be used to develop coordination and referral arrangements between health centers and other agencies, institutions and organizations within their communities that are crucial to the successful management of pregnant women and infants.

Additionally, centers might use funding to develop coordinated delivery and hospital admission programs so that pregnant patients who need high risk delivery services can be moved quickly and smoothly into specialized delivery settings.

The Committee believes that while the basic grant program will permit health centers located in high mortality areas to upgrade, improve and strengthen their own services, there will be women and children whose needs simply exceed the level of care that centers are equipped to furnish. This special supplemental grant program will permit centers to establish programs, standards and referral systems with other segments of the community, for ensuring prompt high quality care when such specialized interventions are warranted.

Because of the continuing problems of perinatal mortality and morbidity, it is the Committee's intent that additional funding for these activities be made available as soon as possible. Therefore, the Committee urges the establishment of a streamlined application and approval process with minimal reporting requirements. In this way, grant funding can be expedited and services made available in a timely basis.

Furthermore, the Committee does not intend that these funds be subject to formal demonstration evaluation procedures. However, in order to evaluate the success of these programs in reducing the incidence of infant mortality, the Committee intends, at a minimum, that the following data be collected: (1) the number of women and infants served; (2) in the case of pregnant women, the trimester of initiation of prenatal care; and (3) the conditions disclosed among pregnant women and infants served. These statistics should be reported to the Secretary annually, in conjunction with other reports already required of CHC and MH grantees. The Secretary shall, in turn, compile the data from various projects and issue a public report.

The Committee is hopeful that these activities will continue and expand through future considerations of the Community and Migrant Health Center legislation.

3. Frontier Areas

During the past year, as the public policy debate of the problems of financing and delivering health care services in rural areas has unfolded, the Committee has become aware of the special problems inherent in attempting to develop and operate health care delivery systems in the most sparsely populated rural areas of America. Borrowing from a DHHS-funded Task Force, the Committee has used the term "frontier" to describe these areas, which are defined as those with a population density of no more than six persons per square mile, spread over a broad geographical area (generally an entire county or multiple counties, although a sub-county area or adjoining parts of two or more counties would also fit this definition).

According to the 1980 U.S. Census, there were at least 382 counties, with a population of nearly 2.9 million persons, which would meet the above definition. These areas are principally found in 20 Western states, and encompass 45 percent of the U.S. land area.

In addition to having sparse population, these areas tend to be geographically isolated, have a fragile economic base and offer limited health services. The geographic isolation and population sparcity of such areas mitigate against traditional approaches to development and efficient operation of ambulatory health care delivery systems. The small size of such systems results in inherent cost inefficiencies, decreased productivity of clinical providers, difficulty in arranging referrals, and difficulties in recruiting and retaining high quality clinical and management personnel.

Despite the fact that most of the residents of the areas are obviously medically underserved, very few CHCs (or even free-standing National Health Service Corps sites) are currently receiving federal support in such areas. In fiscal year 1986, only 17 of the 648 CHC grantees were located in frontier areas as were 38 of 3,127 NHSC assignees. Moreover, the federal expectations and requirements of these sites were the same as those for much larger rural, and even urban, CHC sites. Although the statute permits considerable latitude in designing appropriate CHC systems, the federal program managers appear to have allowed little or no flexibility in permitting grantees to tailor their delivery systems to local needs or to the unique characteristics of these areas.

To remedy this situation, the Committee intends the Secretary to:

Facilitate and support development of grant applications from frontier areas through use of federal technical assistance resources and appropriate state governmental entities and state associations of CHCs, supported under Section 330(f)(1).

Ensure that applications for grant support (whether for planning and development or for operations) are accorded fair and equitable treatment by federal reviewing authorities.

Develop criteria, standards, expectations and requirements for frontier sites which are relevant to their unique operational nature and are different from those for larger operations.

Within statutory limitations, explicitly allow and encourage creative approaches to systems development and operations.

Support and facilitate continued research, data development and efforts to promote a better understanding of the needs of frontier areas, including the work of the Frontier Health Task Force.

The Committee wishes to clarify that it in no way intends to require the Secretary to ignore or waive current statutory requirements in this regard, nor does it expect the Secretary to support systems of care which are inadequate with respect to quality of care or completeness of care. For example, all frontier area CHCs must serve medically underserved populations and must meet the statute's requirements for governance, administration, fiscal and clinical systems and accountability, and the like. At the same time, such CHCs should be expected to make extensive use of mid-level providers, and to provide some services by referral arrangement rather than directly.

B. AREA HEALTH EDUCATION CENTERS (AHEC) PROGRAM

An adequate supply of well trained health care professionals is crucial to the delivery of medical care, including essential prenatal and postnatal care. The Committee recognizes both this fundamental principle and the shortage of health care professionals in underserved areas along the border with Mexico, and in sparsely populated frontier areas.

Section 5 addresses this shortage and seeks to alleviate it by providing for an expansion of the Area Health Education Center (AHEC) program, and by targeting additional resources to Florida and other Southern States, the Pacific Basin region, the area along the Mexican border and frontier areas. The Committee intends for the additional funding to be used to establish new AHECs and expand existing centers to increase and improve the delivery of prenatal and postnatal care in these targeted areas, and in areas with disproportionately high rates of infant mortality.

The AHEC program can play a crucial role in improving health care in these identified shortage areas in at least two important ways. First, the sensitivity of health care professionals to the needs of shortage areas should improve as physicians in training receive valuable experience in AHECs located in or serving shortage areas. Second, providing for training of health care professionals in shortage areas may increase the likelihood that these professionals will choose to practice there, and provide greater access to the needed medical care. The Committee expects those AHECs that receive funding under this section to work closely with C/MHCs, Indian Health Service facilities, and other providers serving the area, and with the statewide organizations representing the centers and other providers, in designing and implementing these new initiatives.

C. FELLOWSHIPS FOR NURSE PRACTITIONERS AND NURSE MIDWIVES

The bill establishes a new program to support the granting of fellowships for the education of nurse midwives and pediatric, family,

obstetric and gynecologic nurse practitioners, authorized at $4 million for fiscal year 1988.

There is a chronic shortage of health care professionals willing to provide high quality services to low income, high risk mothers and infants in rural, inner city, and other underserved areas. Often this shortage can be reduced by increasing the number of nurse practitioners (NP) and nurse midwives (NM) to serve in these areas. An Office of Technology Assessment report recently documented that within areas of competence, NPs and NMs provide care whose quality is equivalent to that of care provided by physicians. The report also credited NPs and NMs with improving the geographic distribution of care because many of them have been willing to locate in underserved rural and inner city areas. The Committee recognizes the critical importance of such practitioners to the success of the expanded perinatal care effort. At the same time, the Committee is concerned with the recent steep decline in the number of students in NP/NM training programs.

Under this new program, grants are to be made to schools of nursing for the establishment of fellowship programs, to assist individuals to meet the cost of educational and living expenses incurred while they are students in the NP or NM training programs. The Secretary is required to prescribe guidelines for such fellowship programs, in consultation with appropriate educational and professional organizations. The Committee does not expect such guidelines to be excessive or burdensome, or to require significant alterations to existing accredited NP and NM educational programs. It is expected that those NPs and NMs assigned to the Native Hawaiian health centers, funded jointly by HRSA and the Kamehameha Schools/Bishop Estate will themselves be Native Hawaiians whenever possible.

Priority for such fellowships is to be given to registered nurses who:

Are employed by CHC and MHC grantees, or by Indian Health Service facilities or Native Hawaiian health centers;

Have been recommended for the fellowships by their employers; and

Agree to return to their employer following completion of NP or NM training and to remain there for a period of time at least equal to the length of their training or education program.

The clear intent of the Committee is to assist the health centers and other facilities to upgrade the capabilities of their staffs, in conjunction with the other activities authorized in the bill. Although the bill would not authorize the extention of salaries of applicants during their training period, the Committee understands that stipends may need to be provided by employers.

V. Committee Action

S. 1441 was introduced in the Senate on June 26, 1987, and referred to the Committee on Labor and Human Resources. The Committee met in executive session on July 1, 1987, and agreed unanimously to report S. 1441 to the Senate.

VI. Congressional Budget Office Cost Estimate

U.S. Congress,
Congressional Budget Office,
Washington, DC, July 29, 1987.

Hon. Edward M. Kennedy,
Chairman, Committee on Labor and Human Resources,
U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for S. 1441, the Public Health Service Act Infant Mortality Amendments of 1987, as ordered reported by the Senate Committee on Labor and Human Resources on July 1, 1987.

If you wish further details on this estimate we will be pleased to provide them.

With best wishes,
Sincerely,

Edward M. Gramlich,
Acting Director.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE, JULY 29, 1987

1. Bill number: S. 1441.
2. Bill title: Public Health Service Act Infant Mortality Amendments of 1987.
3. Bill status: As ordered reported by the Senate Committee on Labor and Human Resources on July 1, 1987.
4. Bill purpose: To reduce the incidence of infant mortality.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Estimated authorization levels:					
Migrant Health Centers	3	—	—	—	—
Community Health Centers	35	—	—	—	—
Area Health Education Centers	3	—	—	—	—
Fellowships for nurse practitioners and nurse midwives	4	—	—	—	—
Total authorization level	45	—	—	—	—
Total estimated outlays	24	15	5	1	—

The costs of this bill would fall within budget function 550.

Basis of estimate: This bill would increase the fiscal year 1988 authorization levels for the migrant health centers, community health centers, and area health education centers programs. The table below shows the current 1988 authorization levels for these programs compared to the levels proposed in S. 1441.

[In millions of dollars]

	1988 current	1988 proposed	Increase
Authorization levels:			
Migrant Health Centers	45.4	48.4	3
Community Health Centers	400	435	35
Area Health Education Centers	18	21	3
Total	463.4	504.4	41

All authorization levels are specified in the bill. Outlays are estimated using spendout rates calculated by CBO on the basis of similar health service spending data.

6. Estimated cost to State and local government: Schools receiving federal support for area health education centers must provide 25 percent of their funds from nonfederal sources. If the additional $3 million is appropriated in fiscal year 1988, schools would have to provide an additional $1 million in nonfederal funds. This money could come from state or local governments.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by Carmela Dyer.

10. Estimate approved by C.G. Nuckols, for James L. Blum, Assistant Director for Budget Analysis.

VII. Regulatory Impact Statement

The Committee has determined that there will be minimal or no increase in the burden of paperwork or additional regulation imposed by this bill.

VIII. Section-by-Section Analysis

Section 1 cites the title of this bill as the "Public Health Service Act Infant Mortality Amendments of 1987", and states the purpose of this legislation, to reduce the incidence of infant mortality.

Section 2 contains findings related to: the serious problems of infant mortality and morbidity on the United States; the failure of the U.S. to achieve significant reductions in the incidence of infant mortality and morbidity and the likelihood that the U.S. Surgeon General's 1990 Health Objectives for the Nation will not be achieved; the importance of expanding access to high quality medical and health care—especially for high risk pregnant women, infants and children—in order to successfully impact on infant mortality and morbidity; and the vital role Community and Migrant Health Centers can play in this effort.

Section 3 amends Section 329(h)(1) of the PHS Act to increase the fiscal year 1988 authorization for the Migrant Health programs by $3 million, from $45.4 million to $48.4 million.

Section 4(a) amends Section 330(g)(1) of the PHS Act to increase the fiscal year 1988 authorization for the Community Health Centers program by $35 million, from $400 million to $435 million.

Section 4(b) amends Section 330(c) of the PHS Act to require the Secretary to give special consideration to the unique needs of frontier areas in making grants under the CHC program.

Section 4(c) amends Section (g) of the PHS Act to require that, for fiscal year 1988, amounts appropriated for the CHC program

which exceed $418 million shall be used to support the cost of delivering special prenatal services designed to reduce infant mortality, and for grants to support special prenatal coordination projects to improve the coordination and delivery of all medical, health and related services for pregnant women and infants, with a priority for areas with high or increasing infant mortality rates.

Section 5 amends Section 781 of the PHS Act to establish a new effort within the Area Health Education Centers (AHEC) program, authorizing grants for the establishment and support of AHEC programs for the training of health personnel to offer maternal and child health services in underserved areas. The bill would increase the fiscal year 1988 authorization level for the AHEC program by $3 million, from $18 million to $21 million, and require that, of amounts appropriated for the AHEC program in FY 1988, $3 million shall be spent for this new effort.

The bill would require the Secretary, in making grants for this new effort, to give priority to programs that will train personnel to provide maternal and child health services along the U.S.-Mexico border, in designated frontier areas, and in areas with disproportionately higher infant mortality and low birthweight rates, when compared with other areas of the state(s) in which the program would operate.

The bill would also permit, under this new effort, the use of grant funds to support medical residency programs in obstetrics and gynecology with at least six first-year residents, and for the training of nurse midwives, as well as nurse practitioners.

Section 6 amends Part A of Title VIII of the PHS Act to add a new Section 823 establishing a new program of Fellowships for Nurse Midwives. Under this new program, grants could be made to public or nonprofit private schools of nursing for the establishment and operation of fellowship programs to train qualified individuals as nurse midwives or a pediatric, family, obstetric or gynecologic nurse practitioners. Such programs must extend for at least one academic year, and must include supervised clinical practice and at least four months of classroom instruction. The fellowship programs must give priority to applicants who are employed by facilities that provide health services to medically underserved populations, such as CHC's and MMHC's, Indian Health Service facilities or Native Hawaiian health centers, and who have been recommended by their employers for fellowships assistance. The bill authorizes the appropriations of $4 million for fiscal year 1988 for such fellowships.

IX. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic existing law in which no change is proposed in shown in roman):

Public Health Service Act

* * * * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * * * *

PART D—PRIMARY HEALTH CARE

Subpart I—Primary Health Centers

MIGRANT HEALTH

SEC. 329. * * *

(h)(1) For the purposes of subsections (c), (d), and (e), there are authorized to be appropriated $43,000,000 for the fiscal year ending September 30, 1982, $47,500,000 for the fiscal year ending September 30, 1983, $51,000,000 for the fiscal year ending September 30, 1984, $45,400,000 for fiscal year 1987 and [$45,400,000] *$48,400,000* for fiscal year 1988. The Secretary may not obligate for grants and contracts under subsection (c)(1) in any fiscal year an amount which exceeds 2 per centum of the funds appropriated under this paragraph for that fiscal year, the Secretary may not obligate for grants under subsection (d)(1)(C) in any fiscal year an amount which exceeds 5 per centum of such funds, and the Secretary may not obligate for contracts under subsection (e) in any fiscal year an amount which exceeds 10 per centum of such funds.

* * * * * * *

COMMUNITY HEALTH CENTERS

SEC. 330. * * *

(c)(1) The Secretary may make grants to public and nonprofit private entities for projects to plan and develop community health centers which will serve medically underserved populations. A project for which a grant may be made under this subsection may include the cost of the acquisition and modernization of existing buildings (including the costs of amortizing the principal of, and paying the interest on, loans) and shall include—

(A) an assessment of the need that the population proposed to be served by the community health center for which the project is undertaken has for primary health services, supplemental health services, and environmental health services;

(B) the design of a community health center program for such population based on such assessment;

(C) efforts to secure, witin the proposed catchment area of such center, financial and professional assistance and support for the project; and

(D) initiation and encouragement of continuing community involvement in the development and operation of the project.

(2) Not more than two grants may be made under this subsection for the same project.

(3) The amount of any grant made under this subsection for any project shall be determined by the Secretary.

(4) In making grants under this subsection and subsection (d), the Secretary shall give special consideration to the unique needs of frontier areas.

* * * * * * *

(g)(1) There are authorized to be appropriated for payments pursuant to grants under this section $400,000,000 for fiscal year 1987 and [$400,000,000] *$435,000,000* for fiscal year 1988.

(2) The Secretary may not in any fiscal year—

(A) expend for grant sto serve medically underserved populations designated under subsection (b)(6) an amount which exceeds 5 percent of the funds appropriated under this section for that fiscal year; and

(B) expend for grants under subsection (d)(1)(C) an amount which exceeds 5 percent of the funds appropriated under this section for that fiscal year.

(3) The Secretary may not expend in any fiscal year, for grants under this section to public centers (as defined in the second sentence of subsection (e)(3)) the governing boards of which (as described in subsection (e)(3)(G)(ii)) do not extablish general policies for such centers, an amount which exceeds 5 per centum of the funds appropriated under this section for that fiscal year.

(4) In any case in which the amounts appropriated under paragraph (1) for fiscal year 1988 exceed $418,000,000, the total amount of any such excess shall be available for grants under subsections (c) and (d) to community health centers to support special prenatal services to decrease infant mortality and special perinatal coordination projects to develop and coordinate referral arrangements between community health centers and other agencies, institutions, and organizations that are crucial to the successful management of pregnant women and infants. In making grants from amounts available under the preceding sentence, the Secretary shall give priority to community health centers in areas in which there is a high incidence of infant mortality or in which there is an increased incidence of infant mortality.

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TITLE VII—HEALTH RESEARCH AND TEACHING FACILITIES AND TRAINING OF PROFESSIONAL HEALTH PERSONNEL

* * * * * * *

AREA HEALTH EDUCATION CENTERS

SEC. 781. (a)(1)*(A)* The Secretary shall enter into contracts with schools of medicine and osteopathy for the planning, development, and operation of area health education center programs.

(B) Under subparagraph (A), the Secretary shall enter into contracts to establish and support area health education center programs which include training of personnel to offer maternal health services and child health services in underserved areas. In entering into contracts under the preceding sentence, the Secretary shall give priority to programs which will train personnel to provide such services in areas along the border between the United States and Mexico, in frontier areas, and in areas in which the rate of infant

mortality and low birthweight are disproportionately higher than such rates for the State in which such an area is located.

* * * * * * *

(c) Each medical or osteopathic school participating in an area health education center program shall—

(1) provide for the active participation in such program by individuals who are associated with the administration of the school and each of the departments (or specialties if the school has no such departments) of internal medicine, pediatrics, obstetrics and gynecology, surgery, psychiatry, and family medicine, *except that a program described in subsection (a)(1)(B) shall only be required to provide for the active participation in such program of individuals who are associated with the administration of the school and each of the departments (or specialties if the school has no departments) of pediatrics, obstetrics and gynecology, and family medicine*;

(2) *except in the case of a program described in subsection (a)(1)(B),* provide that no less than 10 percent of all undergraduate medical or osteopathic clinical education of the school will be conducted in an area health education center and at locations under the sponsorship of such center;

* * * * * * *

(d)(1) Each area health education center shall specifically designate a geographic area in which it will serve, or shall specifically designate a medically underserved population it will serve (such are or population with respect to such center in this section referred to as "the area served by the center"), which area or population is in a location remote from the main site of the teaching facilities of the school which participate in the program with such center.

(2) Each area health education center shall—

(A) provide for or conduct training in health education services, including education in nutrition evaluation and counseling, in the area served by the center;

(B) assess the health manpower needs of the area served by the center and assist in the planning and development of training programs to meet such needs;

(C)*(i) except as provided in clause (ii)* provide for or conduct a rotating osteopathic internship or a medical residency training program in family medicine, general internal medicine, or general pediatrics in which no fewer than six individuals are enrolled in first-year positions in such program; *or*

(ii) in the case of a program described in subsection (a)(1)(B), provide for or conduct a medical residency program in obstetrics and gynecology in which no fewer than six individuals are enrolled in first year positions in such program;

* * * * * * *

(F) conduct interdisciplinary training and practice involving physicians and other health personnel including, where practi-

cable, physician assistants [and nurse practitioners], *nurse practitioners, and nurse midwives;*

* * * * * * *

(g) There are authorized to be appropriated to carry out the provisions of this section $20,000,000 for the fiscal year ending September 30, 1978, $30,000,000 for the fiscal year ending September 30, 1979, $40,000,000 for the fiscal year ending September 30, 1980, $21,000,000 for the fiscal year ending September 30, 1982, $22,500,000 for the fiscal year ending September 30, 1983, $24,000,000 for the fiscal year ending September 30, 1984, $18,000,000 for the fiscal year ending September 30, 1986, $18,000,000 for the fiscal year ending September 30, 1987, and [$18,000,000] *$21,000,000* for the fiscal year ending September 30, 1988. The Secretary shall obligate not more than 10 percent of the amount appropriated under this subsection for any fiscal year for contracts under subsection (a)(2).

Of the amounts appropriated under this subsection for fiscal year 1988, $3,000,000 shall be available for contracts under subsection (a)(1)(B).

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TITLE VIII—NURSE EDUCATION

PART A—SPECIAL PROJECTS

SECS. 820–822.* * *

FELLOWSHIPS FOR NURSE PRACTITIONERS AND NURSE MIDWIVES

SEC. 823. (a) The Secretary shall make grants to public or nonprofit private schools of nursing for the establishment and operation of fellowship programs for the education of nurse midwives and pediatric, family, obstetric, and gynecologic nurse practitioners. Such programs shall meet the guidelines prescribed by the Secretary under subsection (b).

(b) After consultation with appropriate educational organizations and professional nursing and medical organizations, the Secretary shall prescribe guidelines for fellowship programs for the education of nurse midwives and pediatric, family, obstetric, and gynecologic nurse practitioners. Such guidelines shall, as a minimum, require that such a program—

(1) extend for at least one academic year; and

(2) consist of—

(A) supervised clinical practice; and

(B) at least four months (in the aggregate) of classroom instruction,

directed at preparing nurses to deliver pediatric, family, obstetrical, and gynecological services, particularly prenatal care and other services designed to reduce infant mortality.

(c) A fellowship funded under this section shall include, for each year for which the fellowship is awarded, 100 percent of the costs of tuition, books, fees, reasonable living expenses (including stipends), reasonable moving expenses, and necessary transportation.

(d)(1) In order to receive a fellowship funded under this section, an individual must be a registered nurse.

(2) In awarding fellowships funded under this section, a school of nursing shall give priority to any applicant who—

(A) is employed by a facility providing health services to medically underserved populations, such as a community health center, a migrant health center, a facility operated by the Indian Health Service, or a Native Hawaiian health center; and

(B) has been recommended for the fellowship by the facility described in subparagraph (A).

(e) No grant may be made for the establishment and operation of a fellowship program under this section unless this application for the grant contains assurances satisfactory to the Secretary that the program meets or will meet the guidelines which are in effect under subsection (b).

(f) For grants under this section, there are authorized to be appropriated $4,000,000 for fiscal year 1988.

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